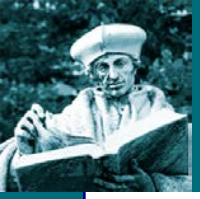

European experience with public-private collaboration in healthcare

Encuentro Nacional de la Salud
Santiago, 23oct15

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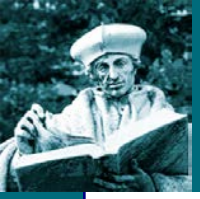
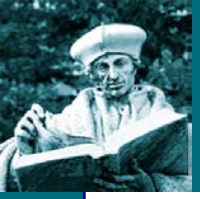


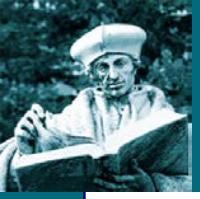
Agenda

1. Competitive health insurance market;
2. Health Insurance in the Netherlands:
   a. similarities public-private mix Chilean & Dutch health insurance;
   b. convergence from three-tier system towards National Health Insurance;
3. Lessons 25 years risk equalization;
4. Chilean health reform Isapres-market.



Competitive health insurance market

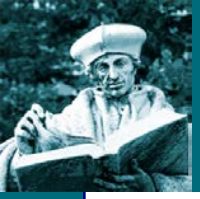
- **Chile** not the only country with a competitive health insurance market;
- Also **Australia, Belgium, Colombia, Czech Republic, Germany, Israel, Ireland, the Netherlands, Poland, Russia, Slovakia, South-Africa, Switzerland, USA.**
- **Global challenge:** How to regulate such healthcare system?



Why not a free market?

Without any government intervention health insurance markets with a 'consumer choice of health insurer' result in:

- Risk-adjusted premiums ('***risk rating***'): the premium differences can go up to a factor 1,000;
- Refusal to accept high risk individuals ('***risk selection***').



Affordability problem

In a free health insurance market with ‘consumer choice of health insurer’ and without any external intervention health insurance may be **unaffordable** for **the (low-income) high risks** because unrestricted competition minimizes the predictable profit per contract.

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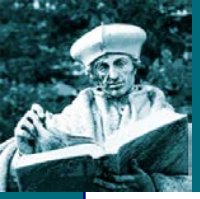
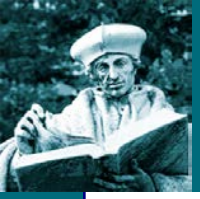


Unrealistic expectations

It is **unrealistic** to expect that a **free** health insurance market without any external intervention results in **risk-solidarity** (i.e. cross-subsidies from the low-risk consumers to the high-risk consumers).

Solidarity requires external intervention, e.g. regulation.



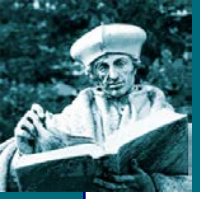
Major challenge

- A major challenge for all countries with a competitive health insurance market:

  .

  How can we organize risk-solidarity (i.e. cross-subsidies form the healthy to the unhealthy people) on a competitive health insurance market?

- Answer: **Risk equalization** (the financial heart of regulated competition in health care).



Why competitive insurance market?

A competitive health insurance market:

- risk-rating and risk-selection;
- health insurance is a complex product, with a lot of small print → → intransparant market;
- complex regulations;
- high administrative costs.

What is the rationale of having a ***competitive*** health insurance market?

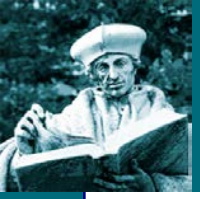
Rationale of competitive HI market?

The insurer being a prudent purchaser of care on behalf of their insured.

Alternative purchasers:

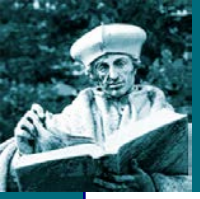
- Consumer / patient?
  - Insufficient information and market power;
  - Due to insurance: no incentive for efficiency;
- Government (Federal, state, local).


Russia
The
NETHERLANDS
U.K.
GERMANY
FRANCE



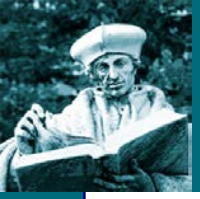
1900-1941: a three-tier system

- **Poor** people: Public provision of care, free of charge;
- **Low/Middle** income: voluntary sickness funds (private initiative, no government regulation);
- **Highest** income: Private, fee-for-service health care.



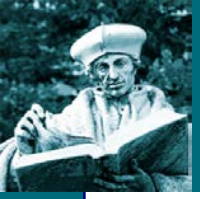
Price discrimination by doctors

- Doctors accepted a **low** capitation fee for sickness fund members if sickness fund would only accept members up to a certain wealth/income level;
- For high-income patients doctors asked a **high** private fee for each item of service.



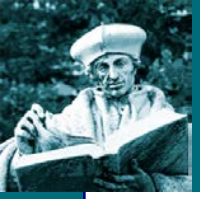
Sickness funds, 1900-1941

- 100's of local sickness funds who are not-for-profit "mutualities" working in local communities;
- Benefits in kind;
- Each sickness fund sets its own premium;
- Community rated premium;
- Membership: 10% (1900) up to 40% (1940).



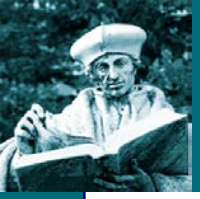
1941 Sickness Fund Act

- **Mandatory** sickness fund membership for employees up to a certain income level;
- Income-related premium to Central Fund;
- Ideally: risk-equalized payments from Central Fund to sickness funds;
- For the time being: 100%-cost-based payments to sickness funds.

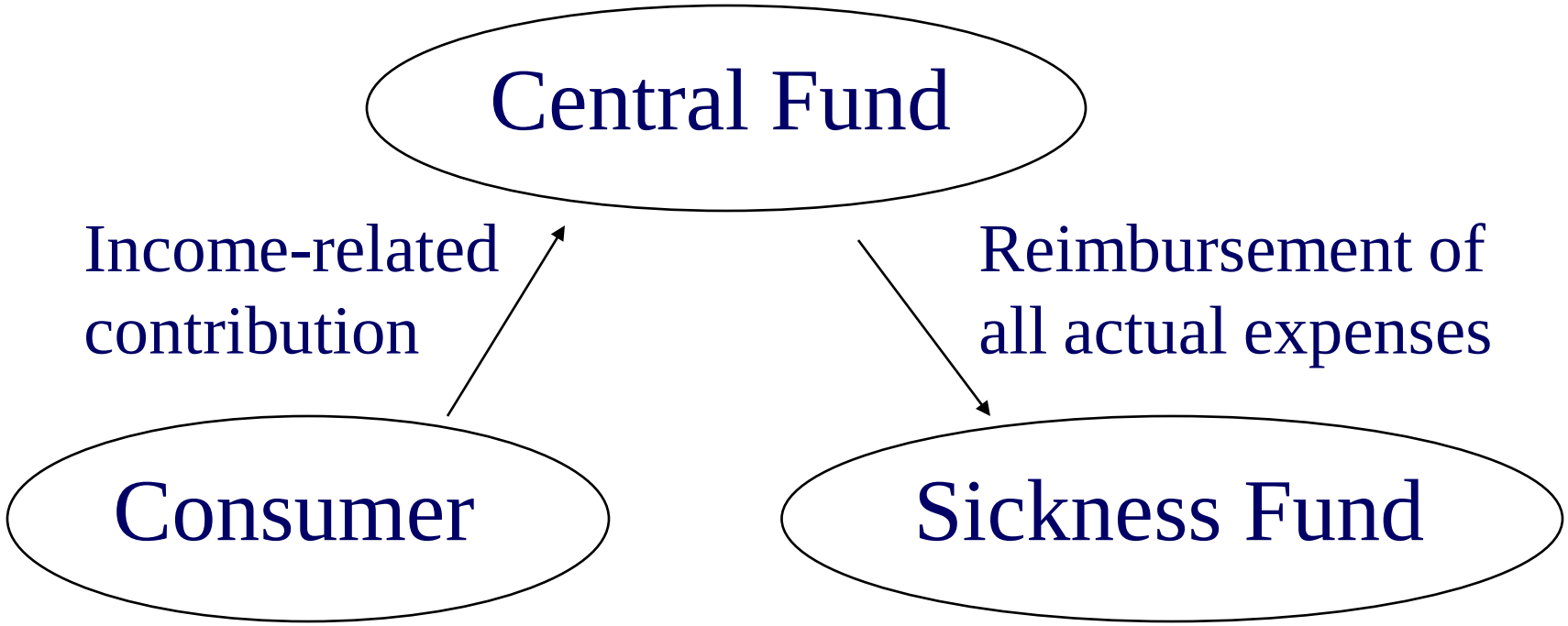


Sickness funds prior to 1941

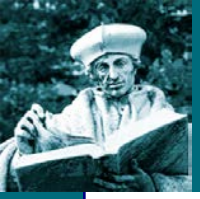
Sickness funds are **financially autonomous** insurance-organizations



Sickness funds 1941-1991

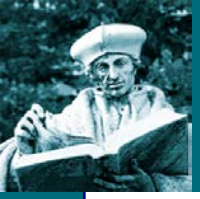


Sickness funds are administrative organizations **without any financial risk.**



1941-2006: a two-tier system

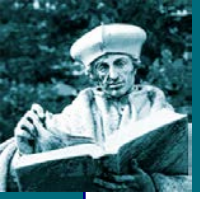
- **Mandatory** sickness fund insurance (SFI) for lower-income people (2/3 population); about 50 regional sickness funds.
- **Voluntary** private health insurance (PHI) for high-income people (1/3 population): increasing problems with risk-rating and risk-selection (Act on Access to PHI, 1986).



Differences public-private HI

Differences public-private health **insurance**:

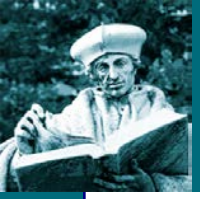
1. Differences in premium;
2. NO differences in use of medical providers, medical treatment or waiting lists;
3. Differences in prices of providers: high prices for privately insured;
4. Gov't regulation forced convergence of prices (**necessary for NHI!).**



Cost containment by gov't

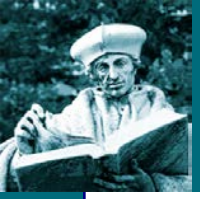
- Price controls; (including a gradual reduction of the huge differences in doctor's fee between SFI and PHI)
- Capacity planning & controls;
- Cost = Price * capacity;
- Macro-budget;

All with respect to private doctors, pharmaceuticals and hospitals.



Dekker-reform proposals (1987)

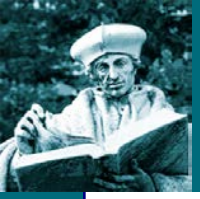
- Regulated competition:
  - among insurers;
  - among providers of care;
- Compulsory health insurance for everyone.



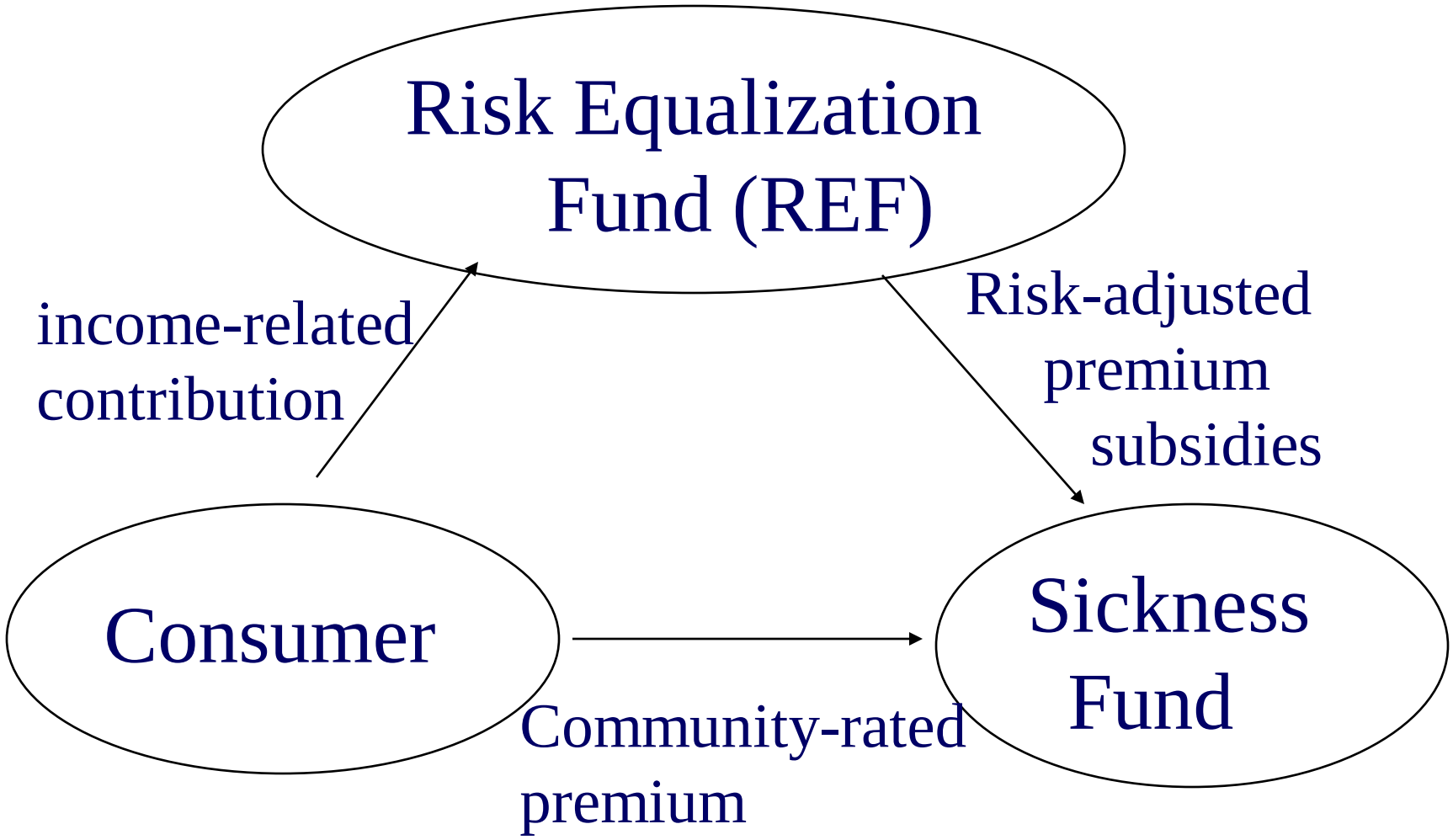
Core of the reforms

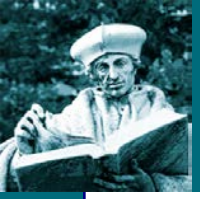
The core of the reforms is that:

- **Risk-bearing insurers will be the prudent buyer of care on behalf on their members;**
- Government will deregulate existing price- and capacity-controls;
- Government will “set the rules of the game” to achieve public goals.



Sickness funds 1991-2005

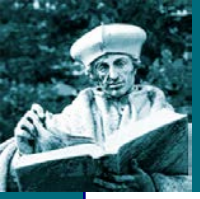




Solidarity and competition

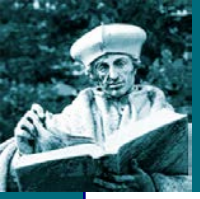
The Risk Equalization Fund (REF) allows to combine solidarity (= cross-subsidies) and a competitive health insurance market:

- Income-solidarity: reflected in the payments from the consumer to the REF;
- Risk-solidarity: reflected in the payments from the REF to the insurers.



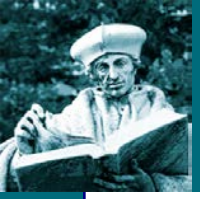
Problems private health insurance

- Risk rating and risk selection;
- Increasing problems of affordability of private health insurance;
- Many elderly and chronically ill people locked in into their ‘old product’;
- Young, low-risk people switch to the cheap new products;
- Self regulation: too weak;



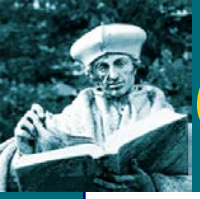
Government regulation (1986)

- Government regulation: open enrolment for high-risk people (about one third), and a maximum premium;
- Insurers strongly and succesfully opposed risk equalization;
- Therefore, 100% ex-post compensation for all expenses above the maximum premium→ no incentive for efficiency.



Levies on premiums

- Financing of these ex-post compensations: via a levy (‘tax’) on the premium of all other privately insured;
- In addition: a levy (‘tax’) on the premium of all privately insured to compensate for the high proportion of elderly in the public health insurance.

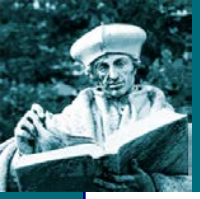


Convergence of public & private HI

After 20 years of convergence the differences between public and private health insurance diminished:

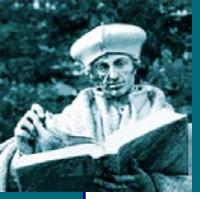
- Medical prices equal for publicly and privately insured;
- Mergers between public and private insurers;
- Public HI market more competitive;

Ready for NHI: **public or private?**



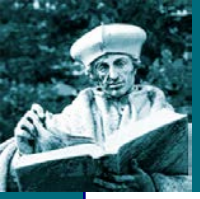
Health Insurance Act NL (2006)

- Mandate for everyone in the Netherlands to buy individual private health insurance;
- Standard benefits package, with broad coverage: described in terms of functions of care (much flexibility!);
- Mandatory deductible: €385 (in 2016) per adult.
- Selective contracting & vertical integration allowed;
- Open enrolment & community rating;
- Risk equalization.



Consumer choice

- Annual consumer choice of insurer and choice of insurance contract:
  - in kind, or reimbursement, or a combination;
  - preferred provider arrangement;
  - voluntary higher deductible: at most ‘plus €500’ per person (18+) per year;
  - premium rebate (<10%) for groups.
- Voluntary supplementary insurance.

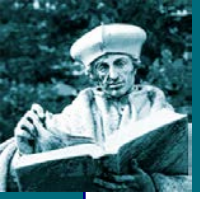


Regulated Competition

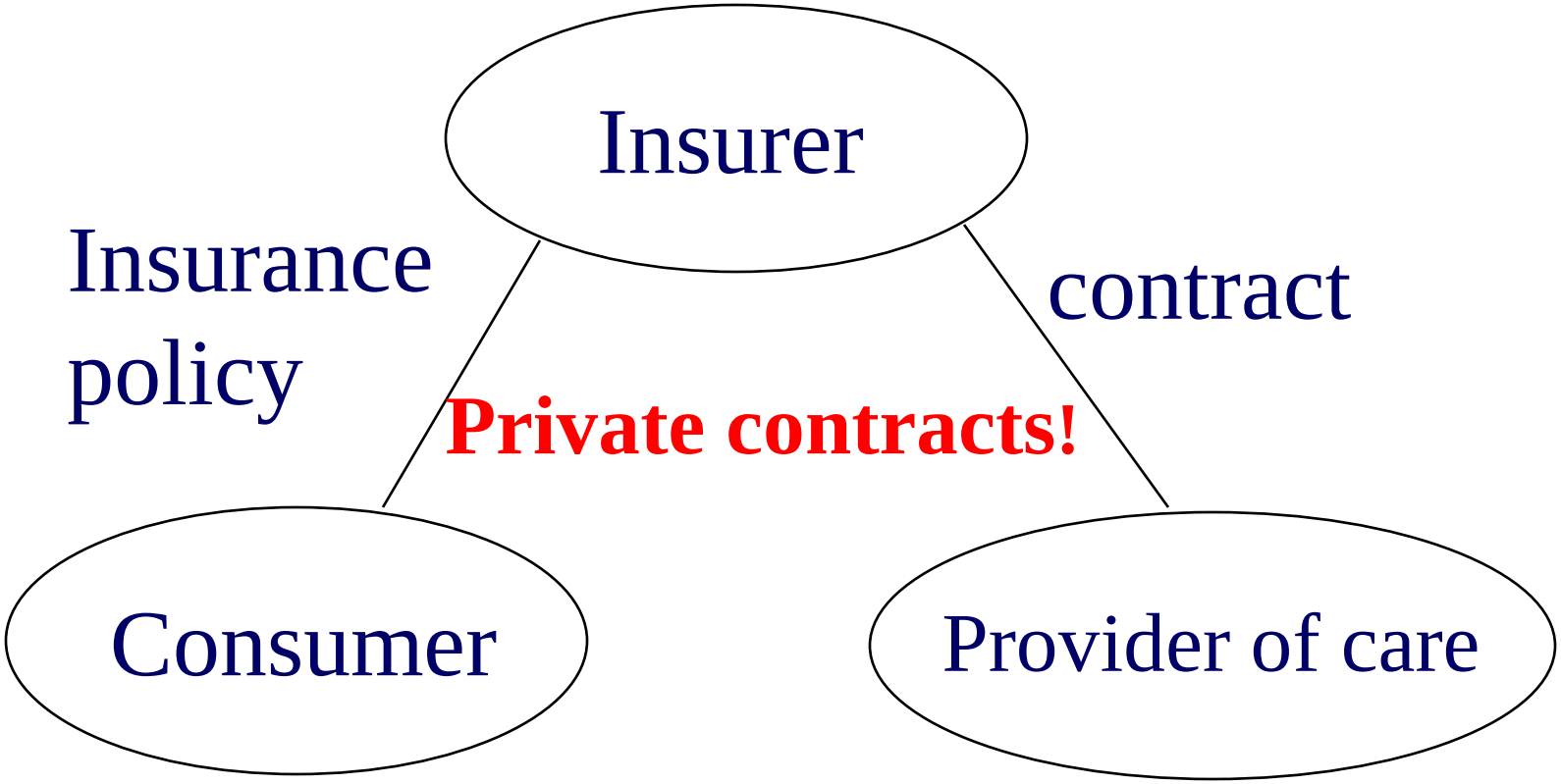
- Competition among *health insurers*:

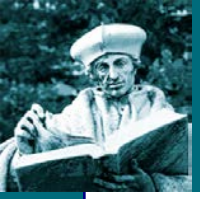
  consumers have a periodic choice among health insurers and insurance products;
- Competition among *providers of care:*

  insurers and providers may selectively contract with each other;
- Not a free market; regulation to achieve society's goals.



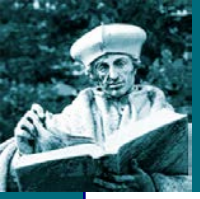
Insurer as purchaser of care





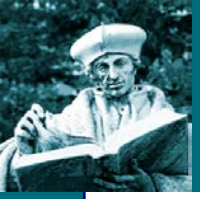
Insurers' duty of care

- Insurers have a so-called 'duty of care': they must guarantee the delivery of care;
- The care must delivered within acceptable maximum waiting times ('national norms');
- Insurers compete (also) on waiting times.
- If an insurer does not fulfill its contractual obligations, the insured can successfully go to court.



Risk Equalization Fund (REF)

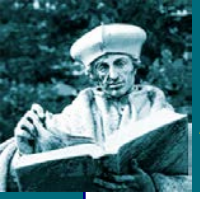
Two thirds of all households receive an income-related care allowance (at most € 1788 per household per year, in 2015)



RE in the Netherlands

An individual's equalization payment is equal to the predicted health expenses based on the individual's risk factors and the equalization formula, minus X euro.

X equals 50% (for adults) of the national average per capita predicted health expenses.
(Negative equalization payments imply payments from the insurer to the REF.)



Annual-premium range

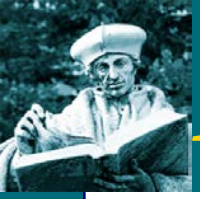
Average premium-2015: €1.158

Minimum premium-2015: €957

Maximum premium-2015: €1.367

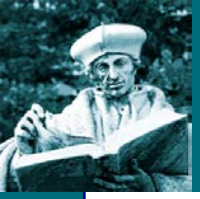
The annual-premium range
(the maximum premium minus the minimum premium for basic health insurance without a voluntary deductible):

- in 2015: €410;
- 2008-2014: between €277 and €340.



Lessons 25 years risk equalization

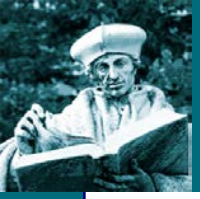
1. Risk equalization appears to be complex in practice. The implementation in practice of even the most simple risk equalization appears to be complex.
2. Without good risk equalization the disadvantages of a competitive market may outweigh its advantages.
3. Invest in appropriate multiyear data for health-based risk adjustment, including a unique identifier per individual.



Lessons learned after 25 years

4. It is very hard to disprove several incorrect argument used in the debate about risk equalization.

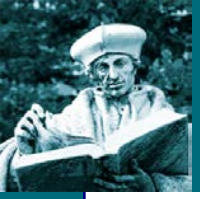
5. Policymakers can easily make mistakes when regulating competitive health insurance markets. Therefore, they should have a good understanding of risk equalization: **why, how,** and **which tradeoffs**.



Tradeoffs

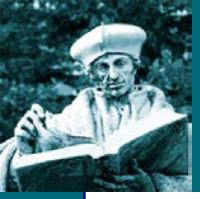
Given insufficient risk equalization policymakers may decide to apply:

- **premium rate restrictions**, resulting in a ***trade-off between affordability and (the effects of) selection;***
- ri**sk sharing** between the risk equalization fund and the health plans, resulting in a ***trade-off between efficiency and selection.***



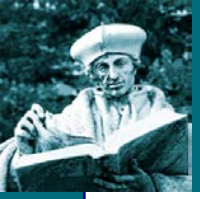
Chile: How to move forward?

- Do not straightforward copy the Dutch steps from three tier via two-tier to one-tier: different situations, background, history, political context, etc.;
- Carefully analyze: what lessons? What is desirable? What is feasible?



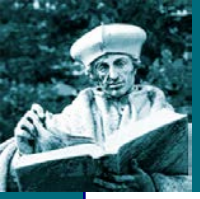
Chile: How to move forward?

- Implement risk equalization and open enrolment step-by-step, and avoid ‘easy’ mistakes;
- Carefully evaluate each step;
- Adverse selection can have catastrophic consequences for the Isapres market;



Chile: How to move forward?

- Protect Isapres against bankruptcies due to adverse selection;
- In the first years there will be large uncertainties for the Isapres about their members, revenues and costs. Therefore, have substantial ex-post compensations to the Isapres in the first years after implementing the risk equalization (just as countries such as the USA and the Netherlands).



Chile: good starting position

Chile has a good starting position because:

- Good data available;
- There already exists a risk equalization system for AUGE-coverage;
- The Isapres have accepted risk equalization and open enrolment for the (39%) captive insured;
- Chile can learn from the experiences and mistakes in other countries.